·		•			
1	EDMUND G. BROWN JR.	•			
2	Attorney General of California JAMES M. LEDAKIS Supervising Deputy Attorney General KATHLEEN B.Y. LAM Deputy Attorney General State Bar No. 95379 110 West "A" Street, Suite 1100				
3					
4					
5	San Diego, CA 92101 P.O. Box 85266 San Diego, CA 92186-5266 Telephone: (619) 645-2091				
6					
7	Facsimile: (619) 645-2061 Attorneys for Complainant				
8	The heye for Companies				
9	BEFORE THE BOARD OF REGISTERED NURSING				
10	DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA				
11		Case No. 2010 - 224			
12	In the Matter of the Accusation Against:	Case No.			
13	CAROL MANUEL GAPASIN 11845 Springside Road	. COVICATION			
14	San Diego, CA 92128	ACCUSATION			
15	Registered Nurse License No. 498948				
16	Respondent.				
17					
18	Complainant alleges:				
19	<u>PARTIES</u>				
20		plainant") brings this Accusation sole			
21	official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),				
22	Department of Consumer Affairs.				
23	2. On or about March 31, 1994, the Board issued Registered Nurse License Number				
24	498948 to Carol Manuel Gapasin ("Respondent"). Respondent's registered nurse license was in				
25	full force and effect at all times relevant to the charges brought herein and will expire on August				
26	31, 2011, unless renewed.		,		
27	///				
28	///				
		1			

STATUTORY AND REGULATORY PROVISIONS

- 3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.
 - 5. Code section 2761 states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct, which includes, but is not limited to, the following:
- (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .
- 6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

7. Regulation 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

2

3 4 5

6 7 8

9 10

12

13

11

14 15

16

17

18 19

20

2	1	

2223

24

25

2627

///

///

28

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

- 9. At all times herein mentioned, Respondent was employed as a registered nurse at Gambro Healthcare University Avenue, an end stage renal disease facility located in San Diego, California (hereinafter "Gambro Healthcare" or "facility").
- On or about October 22, 2004, Patrick M. (hereinafter "patient") was brought to the outpatient clinic at Gambro Healthcare for his first outpatient dialysis after being hospitalized with an acute illness. The patient's pre-dialysis blood pressure was 108/48 and his pulse was 83. At approximately 1:16 p.m., hemodialysis was initiated. At 1:17 p.m., the patient's blood pressure dropped to 77/41. By 1:30 p.m., the patient's blood pressure was 67/32 and at 1:44 p.m., his blood pressure was 72/35. The patient's symptoms of severe low blood pressure continued and he lost consciousness and was foaming at the mouth. At 1:49 p.m., 36 minutes after hemodialysis began, San Diego paramedics were called. The hemodialysis staff was unable to locate an oxygen tank and when they finally did, it was empty. The hemodialysis staff stood by watching the patient and wiped the foam from his mouth, but failed to initiate any life support measures (CPR) or establish an airway. The patient was still sitting in the dialysis chair when the paramedics arrived. The paramedics and fire department personnel reported that none of the hemodialysis staff had initiated CPR or provided respiratory support for the patient even though he was unconscious, unresponsive, and in respiratory and cardiac arrest, that the staff had not brought any emergency equipment, such as a crash cart, to the patient's chair side, and that the patient's blood pressure was 0/0, his pupils were 4 mm dilated and fixed, and his skin was cyanotic. The paramedics immediately took the patient out of his chair and began CPR on the floor. At 2:15 p.m., the paramedics obtained a pulse of 80 and a blood pressure of 118/74 and transported the patient to Alvarado Hospital Emergency Room located in San Diego.
- 11. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 22,

2004, Respondent was guilty of gross negligence in her care of the patient within the meaning of Regulation 1442, as follows:

- a. Respondent placed the patient on *nasal* oxygen at 3 liters per minute despite the patient's cyanotic color and lack of respirations and heart rate.
- b. Respondent failed to provide basic cardiac life support (CPR) for the patient or make any attempts to assist in the patient's rescue.
- c. Respondent failed to record the patient's blood pressure reading, which she had allegedly taken, in the patient's dialysis treatment record ("Post Treatment Report"). Further, Respondent failed to record, or request another staff member to record, the patient's pulse which Respondent had allegedly taken.
- d. Respondent failed to assess or reassess the patient while he was experiencing a medical emergency, and failed to perform any interventions or provide the care required to sustain the patient.
- e. Following the incidents described in paragraph 10 above, Respondent failed to let the facility's Center Director know that all of the hemodialysis staff were not familiar with where the oxygen was kept at the facility.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

- 12. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 and 10 above.
- 13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 22, 2004, Respondent was guilty of incompetence in her care of the patient within the meaning of Regulation 1443, as set forth in subparagraph 11 (c) above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

14. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 9 and 10 above.

Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about October 22, 2004, Respondent committed acts constituting unprofessional conduct in her care of the patient, as set forth in paragraphs 11 and 13 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

- Revoking or suspending Registered Nurse License Number 498948, issued to Carol
- Ordering Carol Manuel Gapasin to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and
 - Taking such other and further action as deemed necessary and proper.

Interim Executive Officer

Board of Registered Nursing Department of Consumer Affairs

State of California

Complainant